

Physical Exam

Initial (baseline)

Date: _____

Return (follow up)

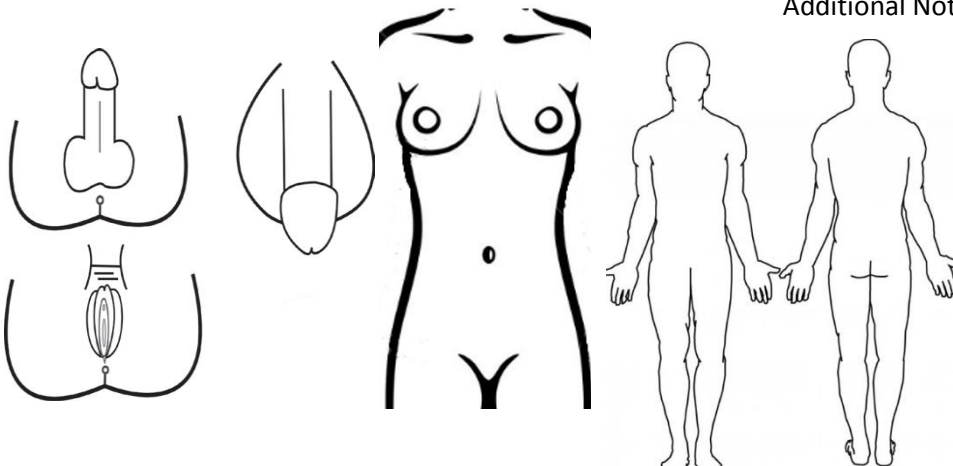
Temp _____ Pulse _____ Resp _____ B/P _____ WT _____ HT _____ G _____ P _____ AB _____ LC _____ LNMP _____

Reason for visit: _____

N=Normal, AB=Abnormal, NE=Not Examined

Review of Systems (subjective)	(Objective)	N	AB	NE	Comments
General:	Skin				
Skin:	Head				
	Eyes				
HEENT:	Ears				
	Nose				
Cardiovascular:	Throat				
Respiratory:	Oral				
	Back/Spine/CVA				
Breasts:	Thyroid				
Gastrointestinal:	Lymph				
	Heart				
GU/Renal	Lungs				
	Breasts				
Musculoskeletal:	Abdomen/FH/FHTs				
	Extremities				
Neuro:	Neuro				
	External Genitalia				
Reproductive:	Vagina				
	Cervix				
Endocrine:	Uterus/UT. Position				
	Adnexa				
Hematopoietic:	Pelvis/Prostate				
	Rectum				

Additional Notes:



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CI. Name: _____

SS# _____

ID# _____

DOB: _____

Physical Exam

Date: _____

Assessment

Plan

Counseling/Education

Return Appointment

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Cl. Name:	_____
SS#	_____
ID#	_____
DOB:	_____